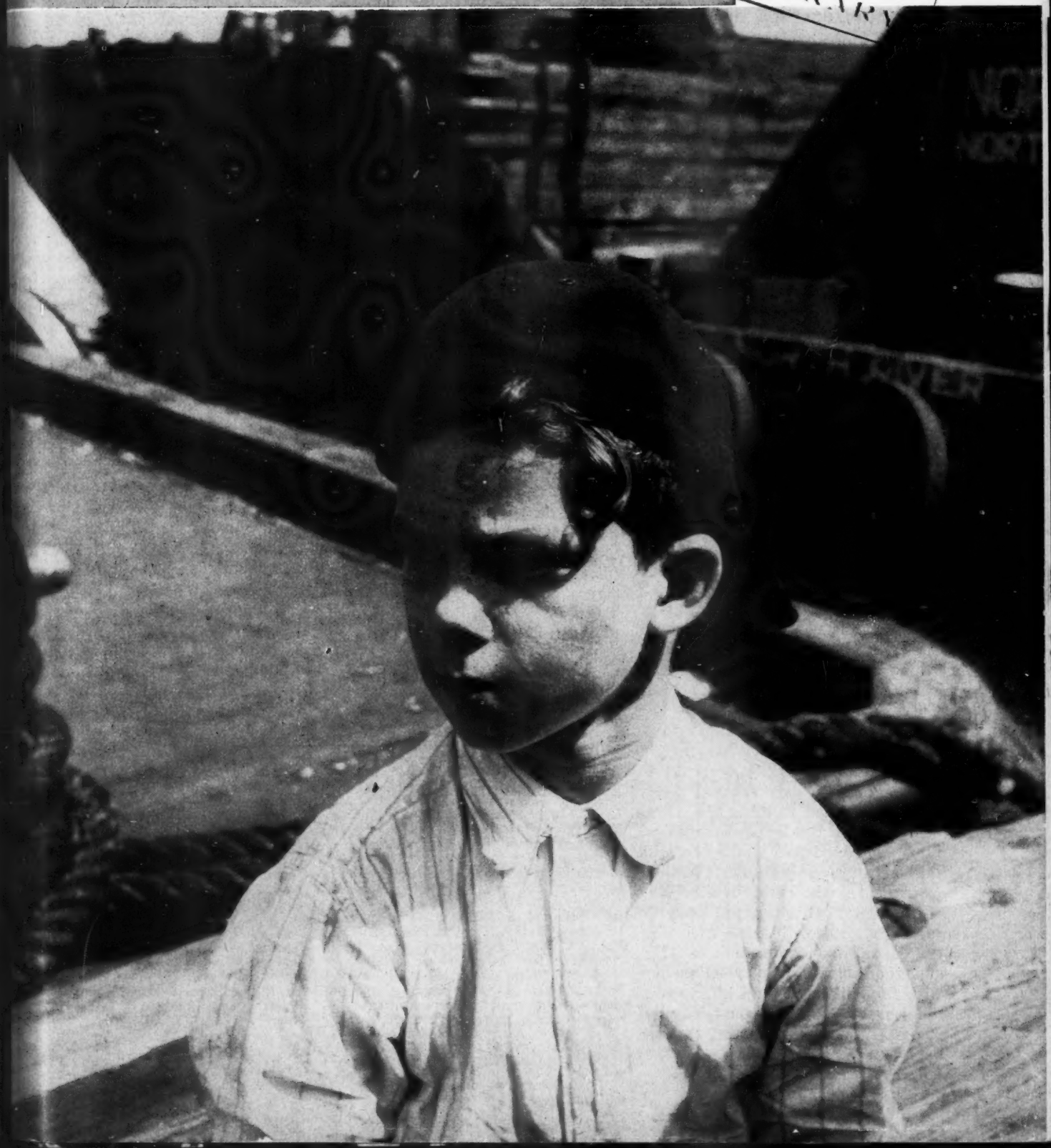
# THE CHILD



APRIL
1952



# HELPING HOSPITALIZED CHILDREN THROUGH SOCIAL GROUP WORK

*GRACE L. COYLE and RAYMOND FISHER*

WHEN a social group worker joins the staff of a children's hospital, he is likely to be viewed at first as responsible chiefly for providing a recreation program. This is natural, as some hospitals have an already established staff position—recreation worker or recreation therapist—into which he steps. It is obviously essential that he know how to organize recreation groups of various kinds suitable to hospital conditions and how to carry out a good recreation program.

As our experience shows, however, such a worker needs to know a great deal more than that. He must, first of all, be able to gain an understanding of each child as an individual. For behind the sullen apathy of Johnny, lodged in his wheelchair, or of Jimmy ruling the ward like a despot as he has always ruled the playground, the social group worker must recognize the distinctive elements in the personality of each of these children, as he struggles to grow up and adjust to the separation from his parents and friends, to the frustration of illness, and to the strange environment of the hospital.

It is always a temptation to a specialist to look at other people through his special lenses; but if the recreation worker regards a child chiefly as a member of a team, or a potential producer of ceramics, or a good lead for a play, he will miss his major opportunity. Rather he must see the child as a whole, with his family background and cultural pattern, with his particular illness and its meaning to him. He can then establish a relationship with the child and help him to use the recreation activities not only as a means of enjoyment but as a help to recovery.

Such a worker must know what he means to the child and how and why the child is reacting to him in a particular way. He has to be able to handle the children's reactions—by turns hostile, overenthusiastic, indifferent, ingratiating, suspicious, or accepting. He will find himself sometimes cast in the role of a substitute parent. Sometimes he will represent a means of escape and a source of pleasure. Occasionally he will need to explain to a child the restrictions and constraints of the medical treatment and hospital care.

Penetration into this vital life stream of a child's world and finding a welcome place in it gives the recreation worker an opportunity to make the child's environment a more relaxed, more accepting, and more satisfying one. Because hospital administrators recognize that a recreation worker needs to understand a child's problems and needs to know how to help him by means of group experiences, they have been seeking professionally trained social group workers to develop the recreation program and related programs as part of the functions of the hospital's social-service department.

The function of the social group worker in a hospital has a basic similarity to his function in any other setting. It is to help individuals, by means of guided group experience, to develop and use their capacities for personally satisfying social relationships; to help them to deal with the problems presented by their environment and to use the resources of this environment in a constructive way. As a result of these positive, progressive experiences the persons who take part in them are enabled to carry more effectively their responsibilities in a democratic society.

In applying these general, basic principles to the specifics of working with hospitalized children, we must clearly understand several considerations that make for some differences in the worker's approach and emphasis in his relationship to his groups and to the members. In the hospital the social group worker represents one of a number of professional disciplines working in cooperation with the physician, who is the key person responsible for the patients. The group worker's function as a member of the social-service department has to be related to

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**This article is based by Miss Coyle and Mr. Fisher on a paper that they prepared for the Midcentury White House Conference on Children and Youth. The paper is one of a number that served as resource material for the Fact Finding Report of the Midcentury White House Conference on Children and Youth, to be published soon by Harper & Bros. The procedures of the conference did not provide for official approval of these papers. Address inquiries to National Midcentury Committee for Children and Youth, 160 Broadway, New New York 38, N. Y.**

**Each child's personality has distinctive elements, and these need to be recognized by the social group worker in her efforts to help the children adjust themselves to separation from their parents, to the frustrations of illness, and to the strange environment of the hospital.**

the services offered by the hospital and be a part of those services.

Another consideration is the impact of the child's illness and hospitalization and its meaning to him. Illness necessitating hospitalization has psychological implications for a child that need to be understood by persons responsible for his care. Separation from the family is a traumatic experience for children, and the shift from home to hospital brings with it many fantasies and anxieties. Removal from home is often viewed by the child as rejection, and the hospital experience as punishment.

### To help children handle their feelings

To a child, a hospital can be a strange and fearful place. Besides being unknown, and possibly representing punishment, the regimented and authoritative aspects of hospital routine (often incomprehensible to the child) make it even more forbidding. The treatment may frighten him, and the pain and anxieties related to the illness itself are often overwhelming. Recognizing this, the social group worker will help a child become acquainted with the hospital and will deal with his feelings of anxiety and fear.

In one hospital for acutely ill children, where the average length of stay was less than a week, the social group worker made it a practice of visiting each child before each group meeting to tell him that the meeting would be held on the ward and to ask what he would like most to do.

She found that often children in adjoining beds could not bring themselves to speak to one another until she introduced them and helped them to become acquainted through relaxed play activities.

The social group worker purposely kept the program very flexible and helped the children decide between such activities as arts and crafts, music, games, discussions, and dramatics.

Sometimes a gift that parents brought set the keynote for the activity. A little girl's cowboy suit, for example, gave the children the idea that they wanted to put on a "wildest west" play. Again, a stuffed animal provided the germ of an idea around which a jungle play could be formed. More often, plays centering about the children's present experiences with illness and treatment were the most popular activity. In these, the children brought out clearly and repeatedly their feelings of anxiety about illness. They dramatized hospital and medical procedures, such as shots, electroencephalograms, and X-rays. They acted out separation from the family and showed the meaning of hospitalization to them.

Often the children would interrupt the play to discuss what they had spontaneously acted out, and would consider whether it was real or make-believe.

In one play the children were showing what happened to put a child in the hospital. The first scene was in the boy's home. He had a minor illness and a doctor was called. Pills were prescribed, but this boy was "bad" and ate more of those "delicious" pills than he was supposed to and as a result had to be hospitalized.

The play was interrupted at this point because the children were interested in talking about whether only bad children were sent to hospitals. This afforded the group worker an opportunity to give them considerable reassurance that they were not being punished, even though she sympathized with them for the treatment they had to endure.

The group then spontaneously continued with the play, this time shifting the scene to the hospital, with the nurses and doctors giving "shots," the nurse giving the little ones and the doctor the big ones. The scene ended with all the children taking turns giving each other shots with clay needles that one of them had been busy preparing.

Through such group sessions the children may be helped to handle their feelings about what has happened to them and may be prepared for procedures that are to come. In their plays centering about the hospital, they think through their feelings instead of repressing them.

They change from the passive role of the patient to the active one of the doctor or nurse, thus reversing the roles and becoming the powerful person who is in control of the situation. They are helped to talk through, or act out, some of their anxieties and, through sharing their feelings, to get acceptance and support from one another.

### Children share experiences

Thus the children are helped to identify with each other on the basis of their sharing difficult experiences (hospitalization, treatment, and separation from families, and their anxieties about these) and sharing also the pleasurable experiences stimulated by the group worker. The group worker represents the warm, sympathetic, and concerned adult; she helps the children to develop a strong bond as they join together in the pleasurable activities.

Endowment of the social group worker with the role of the mother is sometimes even recognized by the children. For example, a 6-year-old boy came running to the group worker when she came on the ward, embraced her, and said he didn't feel too bad that his mother lived too far away to visit him daily because he knew that his "play lady" would come.

Another little boy invariably cried when the worker left the ward after a group session. Finally an 8-year-old took it upon himself to explain to the worker that this boy cried each time his mother left, and also when the worker left, because the worker was "like his mother to him." (These examples occurred during a group-work demonstration by Constance Impallaria, Assistant Professor of Psychiatric Group Work, School of Applied Social Sciences, Western Reserve University.)

A social group worker needs to be able to recognize and understand the relations that inevitably develop among children. Each ward becomes a small social world of its own, and as patients come and go, that world shifts in important ways for every child. (This is true in any hospital but may present special problems in a hospital that provides for long-term treatment and convalescent care.)

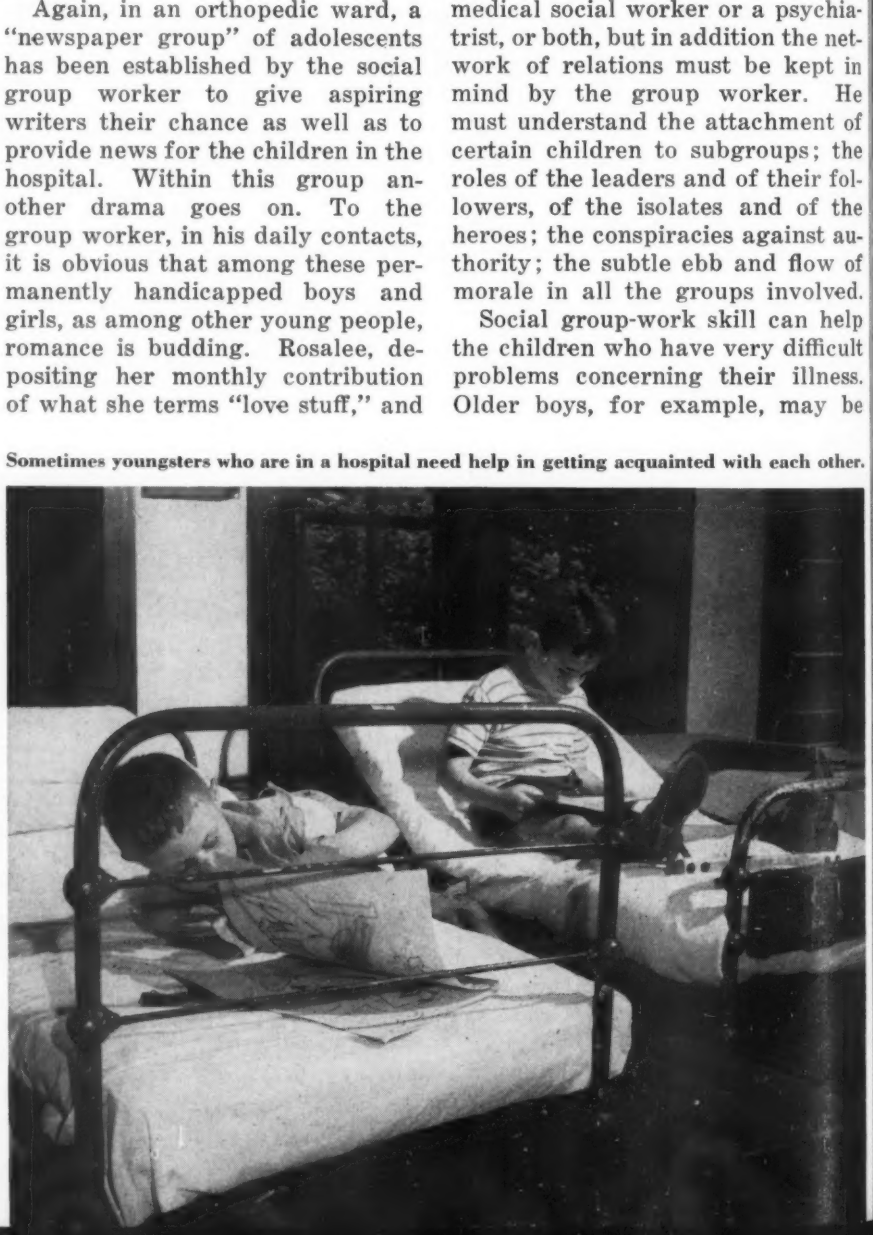
In one corner of a ward, for example, three small girls have established a close-knit subgroup, within which, in spite of occasional squabbles, their mutual support gives each some much-needed affection. Behind this transparent but seemingly impenetrable curtain, which is evident to every other child in the ward, the three have their own special island. From there they throw their barbs of ridicule at the new child in the next bed; they test the nurse to see how far they can go. No child in the ward escapes their scrutiny, and within this small world they are both feared and envied.

Again, in an orthopedic ward, a "newspaper group" of adolescents has been established by the social group worker to give aspiring writers their chance as well as to provide news for the children in the hospital. Within this group another drama goes on. To the group worker, in his daily contacts, it is obvious that among these permanently handicapped boys and girls, as among other young people, romance is budding. Rosalee, depositing her monthly contribution of what she terms "love stuff," and Bobby, turning in his sport column, are also testing their capacities to be like other young people, outside the hospital.

As in any institutional setting for children, at times unhealthy group relations develop, which require special treatment. Such a situation may occur if a group initiates newcomers into sex play; it may show itself in an outburst of behavior problems on a particular ward; it may appear as continued persecution of one unfortunate child, who acts as scapegoat for the group's frustration. Such manifestations represent a group problem. They cannot be handled on an individual basis alone; they must be understood and worked with as group interactions. Some patients may need the individual services of a medical social worker or a psychiatrist, or both, but in addition the network of relations must be kept in mind by the group worker. He must understand the attachment of certain children to subgroups; the roles of the leaders and of their followers, of the isolates and of the heroes; the conspiracies against authority; the subtle ebb and flow of morale in all the groups involved.

Social group-work skill can help the children who have very difficult problems concerning their illness. Older boys, for example, may be

Sometimes youngsters who are in a hospital need help in getting acquainted with each other.



seriously disturbed about the relation of their illness to normal masculinity. Again, children with diabetes, or with an abnormal cardiac condition, may need help in learning to function within the limitations imposed by the illness. The information about the disease, of course, must come from the medical staff. But such information often needs to be supplemented, and a helpful way to do this is through informal discussion groups led by a social group worker who understands children and who is trained in handling discussion.

Such a worker encourages participation by the youngsters and helps them express their feelings and ideas. In this atmosphere the worker can reassure the young patient as much as is consistent with the facts. The therapeutic value of the renewed confidence that children get from such discussions is not yet widely enough recognized.

### Initiative encouraged

Another aspect of hospital life that social group workers must deal with is related to control of behavior problems. In a hospital, medical necessity establishes certain requirements. And many of the behavior problems that arise among hospitalized children are merely those that any child might present, exaggerated, of course, by the results of illness and the restrictions caused by hospital requirements. These problems must be met, but exercise of authority for its own sake, with its overtones of punishment and hostility, obviously does not contribute to a healthy social atmosphere. More successful is constructive use of permissiveness and authority, in proportion as each is needed.

Giving responsibility for parts of the recreation program to self-governed planning committees of children is a device that has been carried over successfully from camps and other groups into hospitals. Such committees are described in an unpublished thesis by Maree Brower, "While Patients Play." (School of Applied Social Sciences, Western Reserve University, Cleveland, Ohio, 1948.) An article based on this thesis was published in **The Child,** October 1950, under the title, "Encouraging Initiative in Convalescent Children."

Self-determination of this sort helps to prevent the increasing dependence, or regression to infantile behavior, that sometimes comes with illness. The spirit of such an approach could well permeate the administration of the hospital as a whole in its dealing with children.

Such recognition and understanding of the social problems that develop in a hospital represents one of the major kinds of help that the social group worker can give a child. This can be done as plans are made for treatment, not only directly, but also indirectly through the other members of the medical team—the doctor, the nurse, and the medical social worker.

Restoration of a child's health can be aided through group work with parents or other relatives. Such groups may meet to discuss common problems in caring for their sick children. These problems might include, for example, how to treat a handicapped child after he returns home, or what help he needs in adjusting to his return to school. Parents often find that the support they give one another strengthens their efforts to help their children toward recovery.

In suggesting these special types of groups, which can and should be developed by group workers in hospitals according to the setting and the need, we are assuming that the social group worker is a trained social worker. Such a worker, like a medical social worker, is equipped with psychiatric knowledge, medical information, and skill in helping people, as well as an understanding of himself; his special skill lies, of course, in his ability to help people primarily through group relations.

It is essential for the social group worker to be able to relate himself helpfully to the hospital as a whole and to the other members of the staff. To do this most effectively he should, we believe, be functioning as a part of the social-service department. Where group workers and case workers operate together they invariably make referrals to one another and share their observations and special knowledge about the children. The result is that some children receive help from both, with each specialist—group worker and case worker—operating more effectively as a result of the joint effort. Consciousness of his own role in meeting the needs of children in a hospital and the ability to work within it is the mark of the successfully trained worker.

The worker must be aware of his function as it relates to that of other people, such as doctors, nurses, attendants, and physical and occupational therapists. In staff meetings or conferences, with medical personnel for example, the social group worker is often able to contribute to diagnostic thinking, through observing the individual child's reaction in the group. He contributes also his knowledge of the social and emotional implications of the hospital experience for the children through sharing with them illustrative material that has come out in group play or group discussion. The social group worker can also take a responsible part in treatment when a doctor suggests that group experience may prove helpful in meeting the needs of a particular child.

### Toward harmony in the group

Another way in which a social group worker should be helpful is in placing a child in a suitable ward group. It is not enough to consider his placement in terms of age, sex, and disease. A factor of major importance to his happiness and perhaps to his recovery is how well he as a person will fit in with the other children into whose social world he is suddenly wheeled. In the children's institution and the camp, we are discovering the importance of skill in grouping. We know that a misplaced child can ruin a harmonious cottage, or a seriously withdrawn child may be subjected to harsh treatment because adults are not alert to the full significance of

*(Continued on page 126)*

# FOR THE HEALTH OF WORKING BOYS AND GIRLS

*REGINE K. STIX, M. D., and ARTHUR LENZ*

NEW YORK STATE recognizes that a boy or girl who is passing through a period of rapid growth and physiological readjustment needs special health protection when he goes to work.

Its child-labor law therefore requires, among other protections, that anyone under 18 years of age who plans to enter employment be given a physical examination before an employment certificate can be issued for him. This requirement applies not only to full-time work, which only boys and girls over 16 can legally enter (unless they are high-school graduates) but also to after-school and vacation jobs, which are permitted for children over 14.

The examination is intended, of course, to make sure that the young worker is allowed to do only work that he is physically fit to do and that will not aggravate any existing impairment of his health.

For instance, a boy may have a heart impairment, and the job that an employer has promised him will require heavy lifting. In this case the examining doctor undoubtedly will not authorize issuance of a **regular** employment certificate, for such a certificate would permit him to take that unsuitable job (if it is lawful for a boy of his age). The law, however, permits the examining physician to authorize the issuance of a **limited** certificate, which will permit the boy to do certain types of work, specified by the doctor, such as clerical work in an office.

If an applicant's condition is very severe, the doctor would refuse to authorize issuance of any employment certificate, although it is unusual for a boy or girl with a serious illness to apply for a certificate.

Although a worker under 18 for whom a regular certificate is issued, for either full-time or part-time work, must apply for a new employment certificate each time he changes his job, he is required to be reexamined by a physician only if the change occurs 6 months or more after the certificate is issued. (Before July 1947 this period was 1 year.) If the certificate is a limited one, the young worker must return for reexamination each time he changes his job; if he does not change jobs he must be reexamined at least once every 6 months.

In New York City the physical examination of applicants for employment certificates is the responsibility of the city Department of Health. (The certificate itself, which has other requirements besides physical fitness, is issued by the Board of Education.)

For many years the Health Department physicians have been giving the examinations in special "working-paper clinics," located in different parts of the city. Since 1946, in an increasing number of high schools, the department has been adding working-paper physical examinations to the other health services it gives the pupils in these schools. An advantage in this latter arrangement is that the examining physician has at hand each applicant's cumulative health record.

The Health Department directs its physicians to pay special attention to handicaps that might hinder the child in his work, and to progressive impairments that might become more serious if the young worker engaged in certain occupations. They are urged to explain to the child and his parents the reasons for postponing or limiting his employment. For example, a doctor who examines a child with sight in only one eye might well guide that child into a job that offered no hazard to his good eye, but he should also explain why he does this, and make clear how important it would be for the worker to safeguard that eye when taking jobs in the future.

On the special record form shown on page 120 of this issue of **The Child,** the examining physician notes the applicant's medical and dental impairments. If an impairment is revealed by the medical history or by the examination, the doctor may issue a limited certificate of physical fitness immediately, on the basis of his own opinion. (This certificate authorizes issuance of a limited employment certificate.) If, however, he wishes to obtain further information or advice, he refers the child to his family physician or dentist, or to a hospital clinic, requesting further information about the applicant's condition. He will tell the applicant to return to the working-paper clinic after the

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**This article is based on a larger report, by Dr. Stix and Mr. Lenz, entitled "Physical Examination for Children Going to Work; an analysis of the records of 2,347 children applying for employment certificates in New York City." The report has been issued in processed form by the Bureau of Labor Standards, U. S. Department of Labor, Washington 25, D. C. Copies may be obtained without charge from that Bureau. The authors' judgments and recommendations are their own, and not those of the Bureau of Labor Standards or of the Children's Bureau.**

needed information has been received. The doctor at the working-paper clinic then decides whether to authorize the issuing office to grant a regular employment certificate or a limited one.

He may, for certain conditions, refer the child to one of the consultation clinics of the Department of Health. At these clinics, specialists in eye, cardiac, orthopedic, and chest conditions are available, and if the applicant's impairment is within one of these fields a specialist will examine him and recommend what care he needs and what kinds of work he can undertake.

The diagnoses and recommendations, whether made at a Health Department clinic or a hospital clinic, or by the applicant's family physician, are sent to the working-paper clinic and are available when the applicant returns for reexamination.

### To improve young workers' health

A few years ago the authors, under the auspices of the Health Department, made a study of a sample of the records of applicants who were given their first physical examination for an employment certificate at one of the working-paper clinics, during the period June 1, 1946, through December 31, 1947. (The records were from five of the six working-paper clinics. No applicant examined at a high school was included.) In these clinics between 80,000 and 200,000 young persons 14-17 years of age are examined each year, the number varying with labor-market conditions.

The study was planned to find out to what extent the examinations given in the working-paper clinics actually were protecting the health of the boys and girls examined. And in view of the health problems brought to light by the examinations, it was expected that the study would suggest further steps that should be taken to improve the health of young workers.

The records were analyzed with three questions in mind:

1. What sort of impairments were found and how frequently were they found?
2. What was done about these impairments?
3. How many children who had been instructed to return for reexamination after going to work returned for such examination, as the law requires?

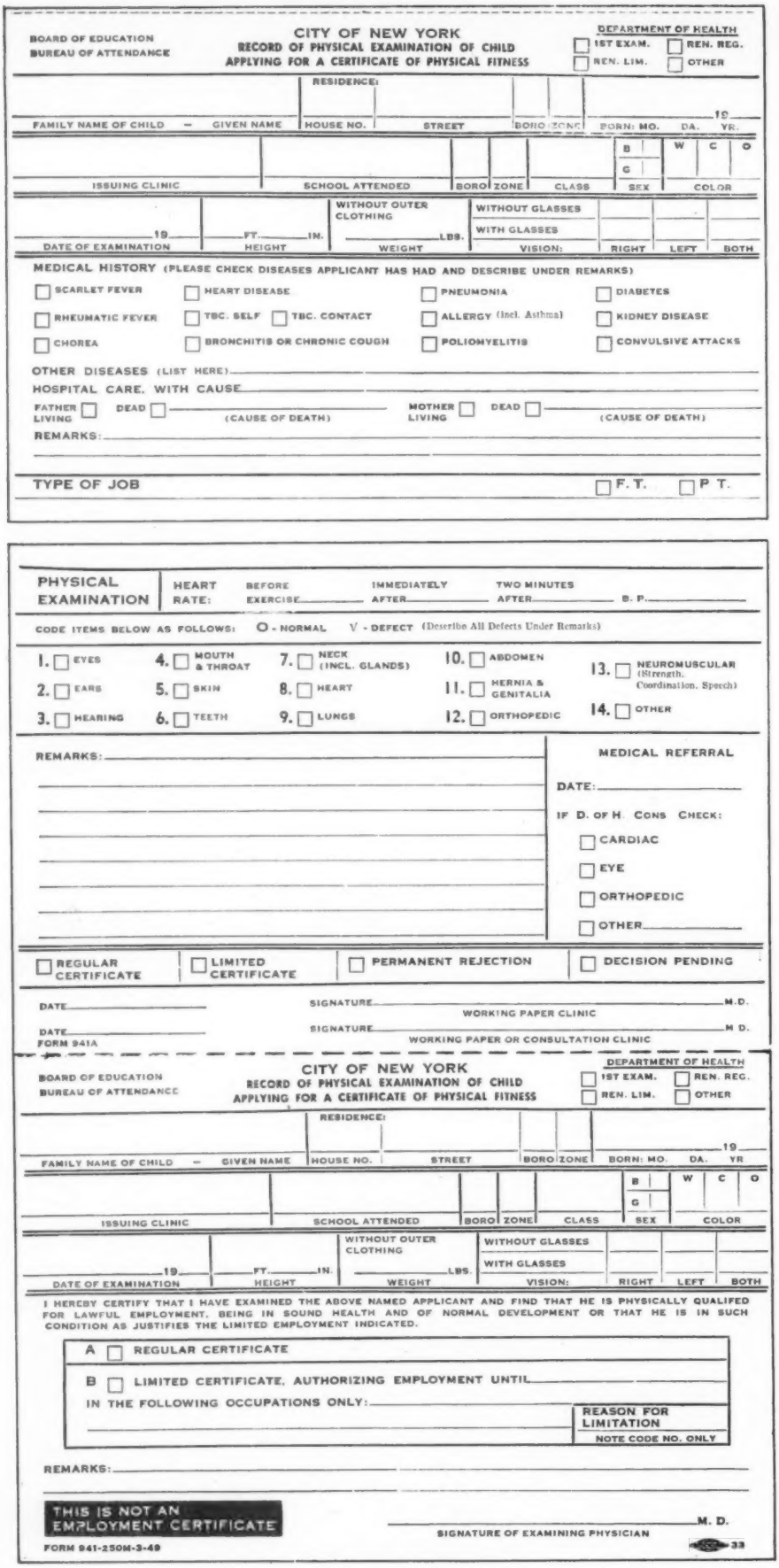
Records of 2,347 applicants were studied, of whom 57 percent were boys. Nearly all were white. Three-fourths were at least 16 when they were examined.

For 83 percent of all the applicants studied, the doctors authorized issuance of regular employment certificates, either before or after the applicant was referred for expert opinion. Limited certificates were authorized for about 14 percent, and the remaining 2½ percent were referred for consultation, but never returned. No applicants were rejected because of impairments.

About a fifth of the applicants had at least one medical or dental impairment. (An impairment as defined for the study was a defect so serious that the doctor either authorized issuance of a limited certificate at once or referred the boy or girl for consultation.) Three hundred and eight of the applicants had medical impairments; of these 38 had dental impairments also. Two hundred and twenty had dental impairments only. The dental impairments were those sufficiently serious to be revealed in an inspection of the mouth by a physician, and to warrant immediate referral for care. It is probable that had the applicants been examined by dentists, more dental caries would have been found.

Since an applicant with extensive dental caries cannot as a rule afford good dental care, the policy was followed when possible of authorizing a limited certificate for such an applicant in order to permit him to earn the money for such care; this was done for about half of these applicants. For 17 percent regular employment certificates were authorized after the applicant had had immediate dental care. One-fourth were referred for care, and then limited certificates were authorized to allow for the completion of dental care begun at the time of referral. Nineteen applicants referred for dental care did not return to the clinic.

**Until a defect in her vision is corrected, this applicant for working papers will not be certified by New York City's Health Department as physically fit to do the job she plans to enter. She is being fitted with eyeglasses at one of the Health Department's consultation clinics.**



BOARD OF EDUCATION
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**CITY OF NEW YORK**
**RECORD OF PHYSICAL EXAMINATION OF CHILD**
**APPLYING FOR A CERTIFICATE OF PHYSICAL FITNESS**

DEPARTMENT OF HEALTH
☐ 1ST EXAM. ☐ REN. REG.
☐ REN. LIM. ☐ OTHER

RESIDENCE:
FAMILY NAME OF CHILD — GIVEN NAME | HOUSE NO. | STREET | BORO | ZONE | BORN: MO. DA. 19 YR.

ISSUING CLINIC | SCHOOL ATTENDED | BORO | ZONE | CLASS | SEX B G | COLOR W C O

DATE OF EXAMINATION 19 | HEIGHT FT. IN. | WEIGHT WITHOUT OUTER CLOTHING LBS. | VISION: WITHOUT GLASSES / WITH GLASSES | RIGHT | LEFT | BOTH

MEDICAL HISTORY (PLEASE CHECK DISEASES APPLICANT HAS HAD AND DESCRIBE UNDER REMARKS)

☐ SCARLET FEVER ☐ HEART DISEASE ☐ PNEUMONIA ☐ DIABETES
☐ RHEUMATIC FEVER ☐ TBC. SELF ☐ TBC. CONTACT ☐ ALLERGY (Incl. Asthma) ☐ KIDNEY DISEASE
☐ CHOREA ☐ BRONCHITIS OR CHRONIC COUGH ☐ POLIOMYELITIS ☐ CONVULSIVE ATTACKS

OTHER DISEASES (LIST HERE)
HOSPITAL CARE, WITH CAUSE
FATHER LIVING ☐ DEAD ☐ (CAUSE OF DEATH) MOTHER LIVING ☐ DEAD ☐ (CAUSE OF DEATH)
REMARKS:

TYPE OF JOB ☐ F. T. ☐ P. T.

**PHYSICAL EXAMINATION** | HEART RATE: BEFORE EXERCISE AFTER | IMMEDIATELY AFTER | TWO MINUTES AFTER | B. P.

CODE ITEMS BELOW AS FOLLOWS: O - NORMAL V - DEFECT (Describe All Defects Under Remarks)

1. ☐ EYES
2. ☐ EARS
3. ☐ HEARING
4. ☐ MOUTH & THROAT
5. ☐ SKIN
6. ☐ TEETH
7. ☐ NECK (INCL. GLANDS)
8. ☐ HEART
9. ☐ LUNGS
10. ☐ ABDOMEN
11. ☐ HERNIA & GENITALIA
12. ☐ ORTHOPEDIC
13. ☐ NEUROMUSCULAR (Strength, Coordination, Speech)
14. ☐ OTHER

REMARKS:

MEDICAL REFERRAL
DATE:
IF D. OF H. CONS CHECK:
☐ CARDIAC
☐ EYE
☐ ORTHOPEDIC
☐ OTHER

☐ REGULAR CERTIFICATE | ☐ LIMITED CERTIFICATE | ☐ PERMANENT REJECTION | ☐ DECISION PENDING

DATE SIGNATURE M.D.
WORKING PAPER CLINIC
DATE SIGNATURE M.D.
FORM 941A WORKING PAPER OR CONSULTATION CLINIC

BOARD OF EDUCATION
BUREAU OF ATTENDANCE

**CITY OF NEW YORK**
**RECORD OF PHYSICAL EXAMINATION OF CHILD**
**APPLYING FOR A CERTIFICATE OF PHYSICAL FITNESS**

DEPARTMENT OF HEALTH
☐ 1ST EXAM. ☐ REN. REG.
☐ REN. LIM. ☐ OTHER

RESIDENCE:
FAMILY NAME OF CHILD — GIVEN NAME | HOUSE NO. | STREET | BORO | ZONE | BORN: MO. DA. 19 YR.

ISSUING CLINIC | SCHOOL ATTENDED | BORO | ZONE | CLASS | SEX B G | COLOR W C O

DATE OF EXAMINATION 19 | HEIGHT FT. IN. | WEIGHT WITHOUT OUTER CLOTHING LBS. | VISION: WITHOUT GLASSES / WITH GLASSES | RIGHT | LEFT | BOTH

I HEREBY CERTIFY THAT I HAVE EXAMINED THE ABOVE NAMED APPLICANT AND FIND THAT HE IS PHYSICALLY QUALIFIED FOR LAWFUL EMPLOYMENT, BEING IN SOUND HEALTH AND OF NORMAL DEVELOPMENT OR THAT HE IS IN SUCH CONDITION AS JUSTIFIES THE LIMITED EMPLOYMENT INDICATED.

A ☐ REGULAR CERTIFICATE

B ☐ LIMITED CERTIFICATE, AUTHORIZING EMPLOYMENT UNTIL
IN THE FOLLOWING OCCUPATIONS ONLY: | REASON FOR LIMITATION (NOTE CODE NO. ONLY)

REMARKS:

THIS IS NOT AN EMPLOYMENT CERTIFICATE

M. D.
SIGNATURE OF EXAMINING PHYSICIAN

FORM 941-250M-3-49 33

Among the 80 children with cardiac findings, nearly all (73) were referred for consultation before any certificate was issued; regular certificates were authorized for 33 of these after consultation. It may be presumed that most of these 33 were children who had only functional murmurs. Limited certificates were authorized for 7 without referral, and for 24 after referral. Sixteen of those referred for consultation did not return.

For about a third of the 141 children with visual impairments limited certificates were authorized without referral for consultation or care. Nearly 40 percent of those referred received regular certificates following referral. It is probable that those receiving regular certificates had little or no functional impairment, once their sight was corrected by glasses. Fifteen of the children referred for consultation never returned and presumably never sought the advice of a specialist.

The remaining 87 children were found to have miscellaneous medical impairments, including orthopedic, nutritional, and skin defects. The number in each group was too small to permit detailed analysis.

Excluding the children with possible cardiac impairments, for whom special care was desirable, it was found that the examining physicians in the working-paper clinics authorized limited certificates for somewhat less than a third of the children with medical problems. In these cases the physician apparently felt that he had gained sufficient information through the examination and the history to be able to make his decision without additional tests or consultation.

Of the 155 applicants with medical impairments who were referred to other clinics or to family doctors 24 failed to return. Of those who did return, however, regular certificates were authorized for nearly half. It thus appears that when an impairment was found or suspected the clinic physcians may have been more cautious than was necessary. It may have been, of course, that the child had received immediate

medical attention which took care of the impairment.

The tendency of clinic physicians to be cautious when they suspect an impairment has been observed repeatedly by one of the authors, who was formerly in charge of the service. The doctor may feel that he is protecting himself from possible legal action in case the child's condition should become worse while he was working in an unrestricted occupation.

For a child who needs to have full confidence in his ability to do what others do, however, this can be very harmful. It may be that additional training of clinic physicians in diagnostic procedures would help to reduce the number of unnecessary referrals for consultation. Possibly also this would mean less unnecessary limitation of the activity of young workers.

As was previously stated, the examining physicians found it desirable to refer many applicants with apparent medical problems to their family physicians, or to a public-health or other clinic for consultation or advice. After referral, however, 18 percent failed to return to the working-paper clinic. Probably some of them went back to school rather than make the effort to seek further medical advice, and some may have worked without employment certificates. Others presumably waited until they were old enough to work without an employment certificate and without going to a doctor.

Before and during the period covered by this study, there was no routine follow-up of children who did not return after medical referral. Since 1948, however, children applying for full-time work who have been referred for consultation and who have not returned have been followed routinely by the city Board of Education's Bureau of Attendance. The attendance officers find that most of these children return to school rather than go for additional medical advice. If the child is not in school, the attendance officer has usually been able to persuade him to go for the medical consultation necessary for the issuance of an employment certificate. If the child is still going to school the information regarding the medical findings is sent to the school public-health nurse for follow-up. If the condition is potentially serious, and the child has left school, the public-health nurse in the district where he lives visits his home to see that he receives adequate medical care.

### Examination has a public-health function

This follow-up procedure is an important advance in policy, for if a medical problem is found but not followed up, the examination of the child has failed partly to fulfill its function. The purpose of a medical examination of a child about to go to work has two aspects. It is (1) a method of making sure that the child will not be employed in an occupation harmful to him and (2) a public-health case-finding procedure that will serve to find the child with impairments who needs medical care. It is useless to find a child who needs medical care if he fails to receive that care.

For this reason special emphasis has been placed on the follow-up of children with medical problems. Authorizing issuance of a limited certificate gives the clinic physician a good opportunity to follow up the child in need of medical care who returns for reexamination. It is important also to make some provision for finding and following the child who fails to return after the medical referral, to see that he too receives whatever medical care he needs.

Follow-up is needed also when a limited certificate has already been issued. Such a certificate was authorized for 14 percent of the applicants studied. To be legally employed they should have returned for reexamination whenever they changed jobs, or at least every 6 months. On the basis of a sample of cases in one clinic, where this information was available, only 35 out of the 55 children for whom limited certificates were issued ever returned for reexamination.

The purpose of the requirement that a boy or girl with a physical defect return for reexamination on each change of job, or at least every 6 months, is to permit the doctor to find out how the young worker's duties are affecting his health, and whether he is receiving adequate medical care.

In a special study of minors working under limited certificates the New York State Department of Labor followed up 159 children so employed, and found that one-fifth of them were working in occupations other than the one described on the pledge of employment for which the certificate had been given.

At present there is no way of checking routinely on the suitability of the work being done by children with limited certificates unless they return for reexamination. It is obvious that better provision should be made for the follow-up of these children to see that they do return.

Of 412 young workers who had been working under regular employment certificates and who returned for reexamination, nine-tenths were again granted regular certificates. Nineteen were denied the regular certificate in order to insure their obtaining dental care and were recommended for limited certificates. Twenty-two had medical impairments, and all were recommended for limited certificates. Only 7 of these were referred for consultation; of the 15 not referred, 13 had visual defects and 2 had presumptive cardiac findings.

Some of these medical problems, including those of the seven children referred for consultation, were apparently newly discovered on reexamination. However, one must question the judgment of the clinic physicians who authorized limited certificates for children previously given regular certificates on the advice of specialists. If a child's condition seemed to have changed he should have been referred for consultation again at the time of reexamination. The data are insufficient for a valid conclusion, but they suggest that some physicians in the working-paper clinics may have been overcautious in authorizing limited certificates and at the same time somewhat careless in not referring children for

additional consultation when indicated.

For 102 out of 138 boys and girls who had been working under limited certificates and who returned for reexamination, limited certificates were again authorized. But regular certificates were authorized for 36 without referral; 15 of these had medical impairments; 21 had only dental ones. For 2 of the 15 children with medical problems their original limited certificates had been issued on the recommendation of a cardiologist. It is possible that two doctors examining a child at different times could disagree on findings, but it is difficult to understand why a physician should, without consultation, authorize issuance of a regular certificate for a child for whom a limited certificate had been recommended previously by a cardiologist.

### Health record important

The failure to refer children for consultation when it is indicated, or to follow the previous recommendations of the consultant if there is no change in the child's condition on reexamination, raises a serious problem. The numbers involved are small in this sample, but they point to the possibility of other similar errors on first examination which would not be apparent in the data available for this study.

It is true that the atmosphere of a busy clinic, especially in the rush of summer applications for employment certificates, is not one that encourages deliberate, thoughtful medical histories and examination. No cumulative health record is available in the clinic, and the young person is anxious only to get his papers so that he can work. It would seem that a much better service for the applicant could be available in his own school, where the school physician has each applicant's cumulative health record and where he is not so pressed for time. Experience in high schools in which examinations for employment certificates are part of the regular health service shows this to be true.

An analysis, for this sample (1946-47), of returns for reexamination as compared with returns for the whole city in 1948 and 1949, reveals a change in pattern brought about by a revision of the law in 1947. The revision reduced from a year to 6 months the period after which the child for whom a regular certificate is issued must return for reexamination if he changes his job. No change was made with regard to limited certificates.

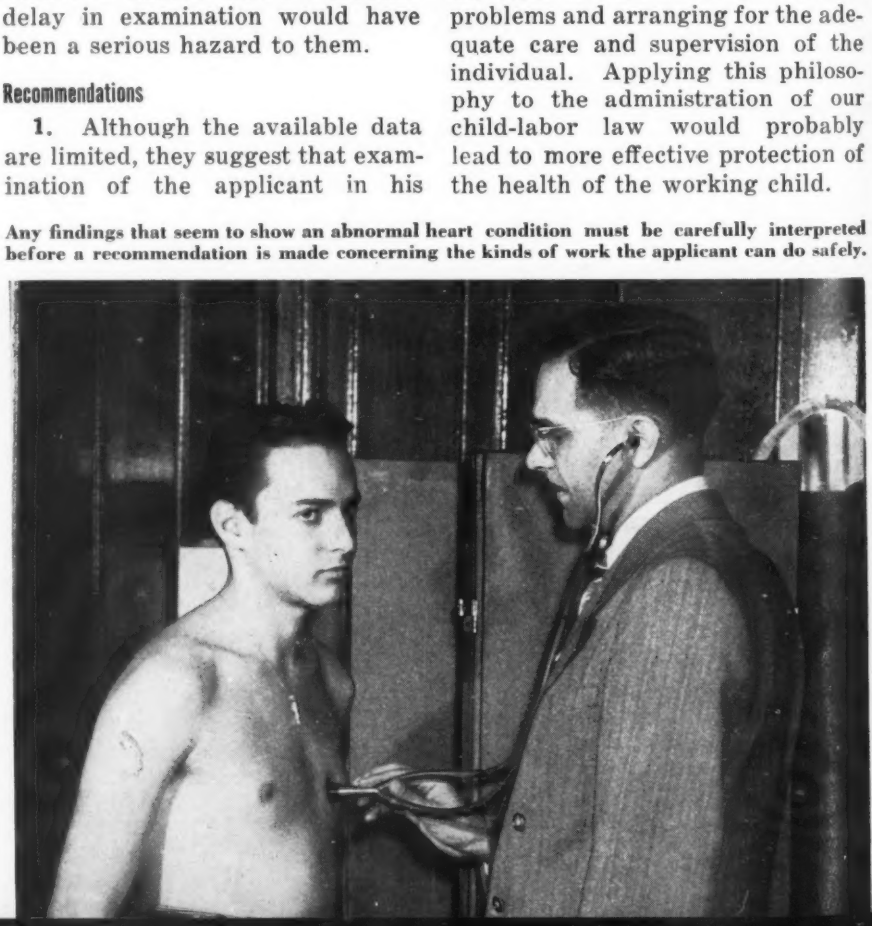
In 1948 and 1949, when children working under regular certificates were required to return for reexamination if they changed jobs 6 months or more after the original examination, the proportion of children returning for renewal of their certificates was approximately double that in 1946 and 1947. This increase places an additional burden on the clinic physicians as well as on the staff of the Bureau of Attendance of the Board of Education—a burden which, however, does not appear to contribute substantially to the health of the children involved. If the findings of this small sample are valid it may be assumed that about 5 percent of these children might have had new medical impairments, but there appears no reason to believe that a 6 months' delay in examination would have been a serious hazard to them.

### Recommendations

**1.** Although the available data are limited, they suggest that examination of the applicant in his school, with his health records at hand, would probably lead to fewer errors in judgment on the part of examining physicians. With the extension of Department of Health services to all senior high schools and an increase in such services in junior high schools, it should be possible to eliminate working-paper clinics for all children in public schools in New York City.

**2.** In our opinion a revision of the law to require less frequent reexamination of children in good health would enable the staff of both the Department of Health and the Board of Education to give more attention to those with medical problems. For example, an annual examination of all children with regular certificates, regardless of change of job, would assure all children some follow-up. The present provisions of the law concerning children working under limited certificates appear to be adequate, but more emphasis should be placed on seeing that **all** these children are followed up to be sure that they receive adequate medical care and proper job-placement services. Current thinking in public health is directed toward finding medical problems and arranging for the adequate care and supervision of the individual. Applying this philosophy to the administration of our child-labor law would probably lead to more effective protection of the health of the working child.

**Any findings that seem to show an abnormal heart condition must be carefully interpreted before a recommendation is made concerning the kinds of work the applicant can do safely.**



# LET'S JOIN HANDS FOR THE GOOD OF CHILDREN

## Children's workers in different professions can meet on common ground

*SAMUEL M. WISHIK, M. D.*

THOSE OF US who are working with children represent many different professions—medicine, education, psychology, social work, nutrition, nursing, nursery education, to name a few. If a good job is to be done for children, no longer can any one of these professions plan or do its work alone. Each profession must draw upon the knowledge and skills of the others.

Such mutual planning and activity can occur: (1) Among the professions, (2) among agencies, and (3) among individuals. Certain principles, which apply, more or less, without regard to the specific profession concerned, can be defined to guide these relationships.

### Professions need each other's help

To promote professional interaction, a minimum core of knowledge should be held by all persons working with children and youth, regardless of specialty. For example, they certainly should be expected to know something about the personality of children—and of adults—and something about the development of personality during the growing years.

Unfortunately, the need for common knowledge and skills is not sufficiently recognized in professional schools. Schools of social work usually require but one elementary course in medical background. Some teacher-training institutions hardly touch upon the growth and development of the normal child. Medical schools should teach more about the social and cultural aspects of health and sickness—for example, family relationships, housing conditions, and dietary practices among certain ethnic groups.

Each profession should, when necessary, leave its traditional sphere and borrow from any profession that can contribute to it. Our present concepts of personality growth have been developed not merely by the fields of pediatrics, social work, psychiatry, and education, but also by the contributions of psychology, sociology, and anthropology.

In addition to a common core of knowledge, people working with children also need to acquire a common set of skills. At least they should have enough skill in dealing with people to permit their professional work to be effective. One skill that we all need, but which is taught in few medical or nursing schools, is interviewing, although we could gain much by borrowing its techniques from the profession of social work. Neither a physician nor a nurse should attempt to be a case worker. On the contrary, it is essential that they recognize their lack of such qualification. They should, however, be sensitive to people, be able to understand their reactions, to pick up leads dropped unintentionally, and to permit flexibility in the progress of the interview.

Lack of understanding of the techniques of interviewing may make us largely ineffective, and we may actually distress the very people we are trying to help.

For example, recently, when a mother asked the pediatrician in a child-health conference about a spot on her baby's cheek, he said merely, "It's nothing." The doctor knew that the spot was unimportant and that it would be gone in a day or two. But a few moments later, this mother, while talking with the nurse, burst into tears and said that she was worried about the spot. When the nurse asked whether she had spoken to the doctor about the spot, the mother sobbed, "Yes, I did. But he is not interested. And I'm afraid that spot is something serious."

In another child-health center, not long ago, a young mother and father came in with their little baby and the grandmother. When the doctor asked, "How's the baby?" the grandmother said the baby was "jumpy." The physician ignored the answer and began to discuss the general care of the baby. Later, it was learned that the baby's father had epilepsy and that the grandmother had not wanted him to get married and have children. The entire family was tensely waiting for the baby to have his first fit.

Now this pediatrician had disregarded the statement that the baby was jumpy because he knew that 2-month old babies normally have a strong startle reflex, and he assumed that was what concerned the grandmother. He was not sensitive enough to detect that there might be a less routine factor in this particular instance.

### We must take a broader view

We in medicine and nursing tend to decide whether or not a problem

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**SAMUEL M. WISHIK, M. D. is Professor of Maternal and Child Health, Graduate School of Public Health, University of Pittsburgh. Dr. Wishik has based this article on a paper that he presented at the twenty-eighth annual meeting of the National Conference of Social Work. Before joining the staff of the University of Pennsylvania Dr. Wishik was Director of the Bureau of Child Health of New York City's Department of Health. Previously he was with the Children's Bureau as Chief of the Program Planning Branch of the Division of Health Services.**

**Skill in interviewing is a valuable asset to a public-health nurse in contacts with families.**

is important in strictly medical terms and not according to the importance of the problem to the person who poses it. What may seem silly from our point of view may be of very great importance to a mother and deserves a careful answer appropriate to her interest.

In an interview, a doctor or nurse often has a certain amount of material that needs to be covered. If skilled in interviewing, however, the worker may temporarily give up the plan to include all the instructions on the list. For if the mother is encouraged to express what she has on her mind, an unexpected opportunity may arise to help her develop an attitude that may benefit the child far more than the planned information.

Another skill that physicians and nurses would do well to acquire is in the technique of guiding group discussions. Of particular value as an adjunct to the usual child-health conference routine, the group discussion has three main values: It facilitates changes in the attitudes of parents, in the attitudes of the staff, and in the focus of the child-health conference.

In the usual interview between doctor and mother, or nurse and mother, the mother asks a few questions and does most of the listening. The content of these interviews is usually limited to the feeding and general child care. In group discussion, however, the mothers do most of the talking and the doctor or nurse does more of the listening. The professional workers learn what the mothers really think and what bothers them most. Stimulated by cross-discussion with other mothers facing similar problems, the mothers are able to talk freely. They are comforted by learning that other mothers have similar problems. And while realizing that every baby is different, each mother is helped to acquire a flexible attitude toward her own child.

Leading a group discussion admittedly requires a skill that is learned through a type of training most doctors and nurses do not have. It is obviously not done by the lecture method.

### For more effective research

Besides borrowing special work skills, the medical, public health, and allied professions can find value in other professions' methods of study and research. Medical research is usually concerned with direct cause-and-effect relationships—what causes a disease, what medicine will cure it. Such disciplines as sociology and psychology have developed investigating techniques that may be adapted so as to be used in evaluating programs, in discovering why parents act as they do toward their children, or in finding out why certain methods do not succeed in changing parents' attitudes and practices in child rearing.

Professional people need to take the initiative in lending as well as in borrowing. For example, the modern public-health nurse working in a school should make every effort to inform the teacher about the health needs and problems of the school-age child. The effective social worker uses each case discussion not only to benefit the child but also to pass along to the other professional workers information and principles that may be useful in meeting the needs of other children in the future.

Professional people need to know about the kinds of special knowledge and skills peculiar to the various specialties dealing with children. Each profession has its own unique contribution, which reaches greater effectiveness when it is fully understood by the other professions. More and more schools of nursing, for example, are giving their students experience in nursery schools, not only so that they can learn to understand little children, but also to observe the methods of nursery educators.

Unfortunately, each profession has developed a language all its own. Even the most intelligent person can be quickly lost in the maze of technical language so familiar to the doctor, or the nurse, or the social worker. As professional people we must make a constant effort to eliminate "jargon" when communicating with anyone outside our immediate group.

If a physician wants to have the school program of a handicapped child changed, he tells the teacher very little when he gives a technical diagnosis of the child's heart condition. Nor does the teacher tell the doctor anything he can understand when she says that the school provides "adaptive physical education." Instead, the physician should state

specifically the kinds and amounts of physical activities the child may not carry on—climbing stairs, dancing, playing baseball, doing setting-up exercises. And the teacher should describe the school program in terms of exactly what physical demands are made upon the children. The doctor and the teacher would then be talking the same language.

To improve the relationships among the professions, then, certain steps must be taken. Changes need to be made in the present methods and content of professional education, both in schools and in post-graduate or in-service training. A minimum common core of knowledge about children should be taught all persons who expect to work with them. A minimum common set of skills must be acquired by these various specialists. They should borrow freely from, and lend to, each other, while nonetheless recognizing the unique function and contribution of each. Finally, terminology should be kept simple, and understandable to the uninitiated.

### Agencies can work together

It is easy to agree that agencies should **plan** together, but not always easy to know just how. For example, planning to meet a community's needs for hospital facilities for children might seem to require only the work of the medical profession. Yet children cannot be treated properly without provision for a number of services, such as convalescent care, including the use of foster homes. So social workers are needed to help in planning the program. Children who are in hospitals for long periods often are able to continue their education, and many need to have some kind of recreation adapted to their needs. So teachers (including nursery-school teachers), recreation workers, and social group workers should also be included in the plans.

Agencies can also cooperate in the **operation** of programs. For example, child-welfare agencies call on health departments for medical services to their clients. (And, incidentally, health departments might cooperate more in social-service exchanges than they do now.) In some communities a step toward teamwork is taken when all agencies agree to use the same type of referral form.

In order that agencies may work together well, their various jurisdictions and areas of interest must be defined. To avoid duplication is only one reason for this; equally important is to avoid omitting necessary services. For example, although children's institutions properly belong under the welfare department, yet the health of these children must be protected; and the health department should contribute to such protection through participation in a program of supervision and consultation. In such a program confusion can be prevented through joint planning and cooperative procedure.

### For teamwork among individual workers

As individuals working with children we can do much to improve the mutual planning and activity of our profession. We must know the resources in our communities for other professional services and the most effective ways of referring children to these services. Private physicians are relatively uninformed about community resources and may spend a lot of time before their patients finally are referred to the most appropriate agency. Social agencies and other professional groups should make every effort to inform physicians about community services.

Professional people can participate on advisory committees for agencies in other fields to help in exchanging points of view. Obviously, the staffs of agencies should learn the value of appointing representatives of various professions to their advisory groups and committees. Of course there must be a balance between committees that include members of other professions and those that are so specialized that only one or two professions are included.

### A good thing can be carried too far

Teamwork among the various professions, particularly when they are all represented in a single agency, is, of course, very valuable. Sometimes, however, such teamwork is distorted by inappropriate procedures. A program may be nullified by too much attempt at teamwork, if no staff member dares to move without first clearing with all the others. Although such clear-

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**A question that seems slight to the doctor may be of great importance to an anxious mother.**

## HOSPITALIZED CHILDREN

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the social relations into which they thrust him.

If we can look ahead to a time when such social group-work services have proved themselves in a sufficient number of places, it is conceivable that the group worker might make a further contribution to the life of the hospital as a whole. The hospital, like the summer camp and the institution for children, offers the child a group-living situation. Although the factor of illness and the requirements of medical treatment make hospital conditions different from most other group-life conditions, many of the basic aspects of hospital life are not unlike those in other institutional frameworks.

Some hospital administrators, in fact, realize that the hospital has group aspects of its own. At a recent meeting of the American Hospital Association one session was devoted to theories of group organization and supervision. It was evident at the meeting that the current interest in the dynamics of the group process, an interest that is evident in education, in personnel management, and elsewhere, had influenced the hospital administrators. If the hospital as a community with a social structure becomes better understood, this will lead inevitably to a realization of the group factors in that community's life. From our present observation of such hospital communities, it is clear that certain group and intergroup relations are of major importance in establishing the social climate in which hospitalized children live.

One of the most important intergroup factors is the relation between various hospital personnel—the administrators, doctors, nurses, therapists of various kinds, social-service workers, and maintenance and service workers. Although these are in one sense personal relations, they also have an important intergroup aspect in terms of the jurisdiction of each and the feeling tones of rivalry or of helpfulness that exist between them. If the social group worker is a member of the social-service staff, as we think he should be, he will contribute to better integration and more mutual helpfulness between the staff groups.

If a group worker is to be equipped to fulfill the functions described here, what kind of training does he require? So far only a few schools of social work are attempting to train group workers especially equipped to work in hospitals. In the writers' opinion, the best training results when a student has a basic first year of social work, including a field placement involving contacts with groups of children. This might be in a settlement house, a children's institution, or some similar situation.

If, at the end of the first year, or the first half of the course, the student is interested in social group work in hospitals, he should take, in addition to the required group-work sequence, courses that will provide the necessary specifics related to the setting, and he should have his field practice in a hospital or a clinic. The courses would include a course in group work in therapeutic settings and additional courses in psychiatry, medical information, and public health. Most important of all, his field experience must enable him not only to adapt his recreation skills and understanding of group work to a hospital setting, but also to fit into a medical team easily and fruitfully. He will need to learn, that is, how to function as a member of the social-service department in a hospital.

Although experience is still too limited to claim substantial results, we believe that the addition of a social group worker to the therapeutic team in a children's hospital will, as time goes on, prove to be a significant new step in the team's efforts to help hospitalized children have a more normal and happy childhood. We believe that it will be a real assistance to children in their struggle to recover.

**Reprints in about 6 weeks**

## LET'S JOIN HANDS

*(Continued from page 125)*

ance is very appropriate at a planning stage it is less so during the operation of a program.

The effective specialist works within his own particular area, but makes it his business to find out enough about the other specialties so that he knows when to call for consultation or to refer the client to some one else. He becomes sensitive to aspects of problems not usually part of his domain.

Close association of individuals from different professional backgrounds should result in their mutual education to the point where each can do his own work more effectively and with a broader approach and can be more sensitive on a selective basis to indications for calling upon the other in consultation, or for referral to the other to take over.

For example, a social worker in a health department will consider that she is doing a successful job when the staff calls upon her less frequently but more selectively, and when she sees that the staff recognizes the social aspects of health care in the services they are giving. When other members of the staff become aware of these social aspects she has a measurement of her own effectiveness and theirs.

We are living in an age of specialization that is good and necessary. Each specialist must be well-grounded in his own discipline. Each specialist must recognize that he exists in a society of other specialists with whom he must work. A pediatrician who does not know about the psychological motivations of parents and a psychiatrist ignorant of normal children are equally ineffective in helping the mother whose child seems to have a feeding problem.

Most of our professions, even the traditional ones, are still rather young, and with youth should retain the flexibility that they need to keep in step with a rapidly changing world.

**Reprints in about 6 weeks**

## IN THE NEWS

**AIIPC.** Martha M. Eliot, M.D., Chief of the Children's Bureau, has been appointed by President Truman as U. S. technical delegate on the Directing Council of the American International Institute for the Protection of Childhood. Elisabeth Shirley Enochs, Chief, International Technical Missions, Office of the Commissioner for Social Security, Federal Security Agency, has been named alternate U. S. technical delegate. Both appointments are for 3-year terms.

Formally established in 1927, the American International Institute for the Protection of Childhood is an intergovernmental body which serves as a center of action, information, advice, documentation, and study on all questions relating to child life and welfare in the Americas. The Institute conducts bibliographical research, collects information by correspondence, and, on the request of member states (the 21 American Republics) undertakes field studies and gives advisory service. United States participation in the Institute was authorized by an act of Congress, approved May 3, 1928. Meetings of the Directing Council, which serves as the governing body of the Institute, are held annually at Montevideo, Uruguay. The last session was held November 30-December 1, 1951.

**Juvenile delinquency.** Upward trends are becoming pronounced in the number of delinquents coming to the attention of juvenile courts and in the number of children who have been arrested by police.

The upswing began in 1949, a year of international unrest, and continued in 1950, the year in which active conflict broke out in Korea.

In 1949, juvenile-court delinquency cases showed an increase of 4 percent over 1948, reversing a downward trend noted each year since the end of World War II. In 1950 the upswing continued, the number showing another 4 percent increase.

An independent series of data, based on police arrests of children under 18 years of age whose fingerprint records were transmitted to the Federal Bureau of Investigation, showed a similar disturbing increase of 4 percent in 1949 over 1948. This increase also reversed the downward trend noted in those data since the end of World War II. In 1950 the increase continued (by 5 percent over 1949), and, in the first 6 months of 1951, police arrests of children were already 9 percent higher than in the first 6 months of 1950.

The figures showing the trend in number of delinquency cases are based on reports from 211 of the more than 400 juvenile courts that report to the Children's Bureau. (The 211 courts form a comparable group for statistical purposes, as their data are available for each of the years 1946-50.) It is estimated that the full annual count of delinquents coming to the attention of all the juvenile courts in the United States is approximately 300,000—4 boys to every girl—and that the annual number apprehended by the police is much greater than that.

Data compiled by the Federal Bureau of Prisons on offenders under 18 charged with violation of Federal laws show also that the trend downward which had continued since 1946 has stopped. There were 1,999 cases of such offenders disposed of by Federal courts in fiscal year 1950 as compared with 1,812 in 1949. The fiscal year 1951 showed 2,130 cases disposed of, a continuation of the upward trend.

**Indonesia.** Approximately 16,000 Indonesian school children are now receiving a daily ration of skim milk and cod-liver-oil supplied by the United Nations International Children's Emergency Fund (UNICEF).

UNICEF aid in Indonesia also includes supplies for a program to combat yaws, assistance in maternal and child-health services, and fellowships.

**Mental Health** of the Child in Conflict With the Law will be discussed by one section of a mental-health workshop to be held at this year's convention of the International Council for Exceptional Children. The convention, which is the thirtieth annual meeting of the Council, will be held at Omaha, Nebr., April 30-May 3.

**To Our Readers—**

We welcome comments and suggestions about **The Child.**

## CALENDAR

*(Continued from page 128)*

**May 23-25.** Young Men's Christian Associations, National Council. Annual meeting. Detroit, Mich.

**May 25-30.** National Conference of Social Work. Seventy-ninth annual meeting. Chicago, Ill.

**Some other organizations meeting in association with the National Conference of Social Work:**

American Association of Group Workers.

American Association of Medical Social Workers.

American Association of Psychiatric Social Workers.

American Association of Social Workers.

Association for the Study of Community Organization.

Big Brothers of America.

Child Welfare League of America.

Florence Crittenton Homes Association.

Medical Social Consultants in State and Local MCH and CC Programs (May 24-25).

National Association of School Social Workers.

National Association of Training Schools.

National Child Labor Committee.

National Committee on Services to Unmarried Parents.

National Probation and Parole Association.

National Publicity Council for Health and Welfare Services.

**May 26-28.** National Council of Juvenile Court Judges. Fifteenth annual conference. Indianapolis, Ind.

**May 26-29.** National Tuberculosis Association. Forty-eighth annual meeting. Boston, Mass.

**May 27-31.** American Association on Mental Deficiency. Seventy-sixth annual meeting. Philadelphia, Pa.

**May 28.** Young Women's Christian Association. Forty-fifth annual meeting of the National Board. New York, N. Y.

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**Illustrations:**

**Cover and pages 115, 116, and 125, Esther Bubley for Children's Bureau.**

**Pages 119 and 122, New York City Department of Health.**

**Page 124, Arch Hardy for Children's Bureau.**

THE CHILD

VOL. 16 NO. 8

APRIL 1952

# In This Issue



**Published 10 times a year by the Division of Reports, Children's Bureau**
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**Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children. The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau. THE CHILD is sent free, on request, to libraries and to public employees in fields concerning children; address requests to the Children's Bureau, Federal Security Agency, Washington 25, D. C. For others, the subscription price is $1.25 a year; send your remittance to the Superintendent of Documents, Government Printing Office, Washington 25, D. C.; foreign postage, 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.**

## CALENDAR

**May 1.** Child Health Day.

**May 1-7.** Correct Posture Week. Sponsored by the National Chiropractic Association.

**May 2-3.** American Council on Education. Thirty-fifth annual meeting. Chicago, Ill.

**May 4-8.** Boys' Clubs of America. Forty-sixth annual meeting. Columbus, Ohio.

**May 4-9.** Camp Fire Girls Triennial Conference. New York, N.Y.

**May 4-10.** National Hearing Week. Twenty-fourth annual observance. Information from the American Hearing Society, 817 Fourteenth Street, N.W., Washington 5, D.C.

**May 4-10.** National Mental Health Week. Information from the National Association for Mental Health, 1790 Broadway, New York 19, N. Y.

**May 4-11.** National Family Week. Tenth annual observance, by Protestant, Catholic, and Jewish groups. Information from the National Council of the Churches of Christ, 79 East Adams Street, Chicago 3, Ill.

**May 5-6.** Society for Pediatric Research. Twenty-second annual meeting. Old Point Comfort, Va.

**May 7-9.** American Pediatric Society. Sixty-second annual meeting. Old Point Comfort, Va.

**May 8-9.** National Midcentury Committee on Children and Youth. New York, N. Y.

**May 8-11.** American Psychoanalytic Association. Annual meeting. Atlantic City, N. J.

**May 12-17.** General Federation of Women's Clubs. Sixty-first annual convention. Minneapolis, Minn.

**May 19-21.** National Congress of Parents and Teachers. Fifty-sixth annual convention. Indianapolis, Ind.

**May 22-25.** National Federation of Settlements and Neighborhood Centers. Thirty-seventh annual conference. Milwaukee, Wis.

**May 23-24.** Boy Scouts of America. Forty-second annual meeting of the National Council. New York, N. Y.

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U. S. GOVERNMENT PRINTING OFFICE: 1952-952608